

STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the Revocation of the  
License of West Metro Recovery  
Services, Inc.

**FINDINGS OF FACT,  
CONCLUSIONS AND  
RECOMMENDATION**

This matter came on for hearing before Administrative Law Judge Kathleen D. Sheehy on April 22-25, 2008, at the Office of Administrative Hearings. The OAH hearing record closed following the receipt of post-hearing submissions from the parties on May 16, 2008.

Cara M. Hawkinson, Assistant Attorney General, Suite 900, 445 Minnesota Street, St. Paul, MN 55101, appeared on behalf of the Minnesota Department of Human Services (the Department).

Dennis B. Johnson, Chestnut & Cambronne, PA, 204 North Star Bank Building, 4661 Highway 61, White Bear Lake, MN 55110, appeared for West Metro Recovery Services, Inc. (West Metro).

**STATEMENT OF THE ISSUE**

Did the Department establish reasonable cause under Minn. Stat. § 245A.08, subd. 3 (2006), to revoke West Metro's license to provide outpatient chemical dependency treatment?

The Administrative Law Judge concludes the Department has met its burden of showing reasonable cause to revoke the license.

Based on all the files, records, and proceedings herein, the Administrative Law Judge makes the following:

**FINDINGS OF FACT**

1. L.D.D., Inc., d/b/a West Metro Recovery Services, is a licensed provider of outpatient chemical dependency treatment services located at 5810 42<sup>nd</sup> Avenue North, Robbinsdale, Minnesota.<sup>1</sup> West Metro has been licensed since approximately 1990. Pat Mus is the sole shareholder and director of L.D.D., Inc.<sup>2</sup> Pat Mus was the treatment director of West Metro until November 2006. Sam Stern is an attorney who worked as the executive vice-president and

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<sup>1</sup> WMRS Ex. 101.

<sup>2</sup> Testimony of Samuel Stern.

general counsel for West Metro from September 2001 through November 2006, at which time he became the treatment director.<sup>3</sup>

2. L.D.D., Inc., also operates a nonprofit corporation called Lifetime Transitions. Since approximately 2001, Lifetime Transitions has been a tax-exempt charitable organization under § 501(c)(3) of the Internal Revenue Code.<sup>4</sup> Lifetime Transitions owns residential property (townhomes and single-family homes) that are used as sober housing for persons going through chemical dependency treatment at West Metro. The sober housing is also available to any person who can pay the rent from other sources. The sober housing operation is not licensed by any government agency.

3. West Metro developed what it called a “housing plus” model of treatment. Pursuant to this model, Lifetime Transitions provided sober housing, food, clothing, and transportation, and West Metro provided outpatient treatment to persons who lived in the sober housing. The cost of the housing program was covered by individual rental payments, public welfare benefits, and charitable contributions. The housing program was also subsidized or underwritten by payments received for outpatient chemical dependency treatment.<sup>5</sup>

4. Hennepin County enthusiastically supported the “housing plus” model.<sup>6</sup> West Metro contracted with Hennepin County to be a provider of outpatient treatment services for low-income persons and persons on public assistance through the Consolidated Chemical Dependency Treatment Fund.<sup>7</sup> Eventually Hennepin County referred more than 500 clients per year to West Metro for outpatient treatment.<sup>8</sup>

5. Beginning in 1999, West Metro aggressively expanded its inventory of sober housing for use with its Intensive Outpatient Program and as transitional sober housing for graduates of treatment programs. As of December 2004, West Metro “had 52 beds available for treatment clients/transitional housing.”<sup>9</sup> In April 2007, when its license was revoked, West Metro had 17 residential properties available for sober housing. Between 1,400 and 1,500 persons per year received treatment through various programs offered at the facility. Up to one hundred people per day attended group sessions there.<sup>10</sup>

6. West Metro’s “housing plus” program was ripe for conflict with licensing requirements. West Metro has always been licensed as an outpatient

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<sup>3</sup> Test. of S. Stern. Mr. Stern returned to private practice in approximately January 2008.

<sup>4</sup> *Id.*

<sup>5</sup> Testimony of Pat Mus; Testimony of Robert Olander.

<sup>6</sup> Test. of R. Olander.

<sup>7</sup> Minn. Stat. § 254B.03. West Metro was not a vendor certified by the County to provide room and board under the Consolidated Chemical Dependency Treatment Fund. See Minn. Stat. § 254B.05, subd. 1.

<sup>8</sup> Testimony of Robert Bakken.

<sup>9</sup> DHS Ex. 39 at DHS 382 (West Metro Employee Manual).

<sup>10</sup> Test. of P. Mus.

program, not as a residential program. Residential programs are required to provide, among other things, 24-hour-a-day supervision of clients.<sup>11</sup>

7. From the time of West Metro's licensure in 1990 until December 2004, the rules governing outpatient chemical dependency providers were contained in 9530.5000—.6400 (then known as Rule 43). These rules were adopted in the 1970s and had relatively few standards regarding qualifications of staff or the manner in which chemical dependency treatment services were delivered. The rules concerning licensure of inpatient residential programs (known as Rule 35) were much more rigorous.<sup>12</sup>

8. In November 2001, the Department conducted a complaint investigation and licensing review of West Metro. The Department issued a Correction Order finding a number of serious licensing violations, as well as an Order of Conditional License, placing the license on conditional status for two years. The violations included deficient procedures for handling suspected maltreatment of minors and adults; deficient assessment of vulnerable adults; inadequate employee orientation about policies concerning vulnerable adults and HIV minimum standards; failure to document staff development training, competency, and freedom from chemical use problems; and failure to maintain a written file for a client. The Department found many deficiencies in West Metro's treatment plans; some clients had no plans, some plans existed but were not signed by clients or staff, and there were no weekly progress notes or revisions to treatment plans in the course of treatment. Some files were missing discharge summaries. The Department also found that West Metro had failed to comply with its own admissions procedures by admitting a person who had debilitating psychiatric problems, who later overdosed in the housing provided by Lifetime Transitions. Furthermore, West Metro had failed to submit a background study request for one staff person.<sup>13</sup>

9. In addition, the Department found that West Metro and Lifetime Transitions were being operated together as a residential treatment program without the necessary licensure for residential treatment.<sup>14</sup> One of the terms of conditional licensure was that:

Within 15 days of receipt of this order, you must submit written policies and procedures describing how you will maintain a strict landlord/tenant relationship with any client who chooses to live in one of your residential settings. The policies and procedures must state that the house managers at the residences may not report client behaviors to the program staff, that no program staff may provide supervision at the residential settings, and that the clients' continuance in the treatment program is not contingent upon

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<sup>11</sup> Minn. Stat. § 245A.02, subd. 14 (2006); Minn. R. 9530.6430, subp. 2; 9530.6505, subp. 1.

<sup>12</sup> Testimony of Julie Reger.

<sup>13</sup> DHS Ex. 60.

<sup>14</sup> *Id.*

behavior and rules compliance at the residential setting. Within 30 days of receipt of this letter, you must submit written documentation that all staff persons and house managers have received training in the written policies and procedures that [meet] these requirements.<sup>15</sup>

10. West Metro did not seek reconsideration of the Correction Order.<sup>16</sup>

11. After two years of conditional licensure, West Metro regained its unconditionally licensed status in 2003.<sup>17</sup>

12. In October 2004, the Department issued another Correction Order in response to a complaint investigation. The Department found that West Metro staff members were improperly providing supervision at the housing facility. The Department again cited West Metro for providing residential services without a license to provide residential treatment. The Department ordered the following corrective action:

Immediately and on a continuing basis, the license holder must not provide any residential services to outpatient clients in the program. The license holder must not allow any person employed by West Metro Recovery Services to provide supervision at the housing facility where the outpatient clients live. West Metro Recovery Services must maintain strictly a landlord/tenant relationship with clients who are living at the housing facility.<sup>18</sup>

13. West Metro did not seek reconsideration of this Correction Order.<sup>19</sup>

14. Effective January 1, 2005, the rules governing licensed chemical dependency treatment programs were amended. The new rules (known as Rule 31) preserve the distinction between residential and outpatient licensure, but they made outpatient treatment programs subject to many of the more rigorous rules and standards applicable to residential programs. This change in the rules was a major shift for outpatient treatment providers in terms of the delivery of services and the qualifications of persons who could provide treatment services. In the reviews done to date, DHS has found many programs to be out of compliance with the new rules and has issued correction orders and other adverse actions aimed at achieving and maintaining compliance.<sup>20</sup>

15. In November 2005, the Department performed a licensing review of West Metro's compliance with Rule 31. In February 2006, the Department

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<sup>15</sup> DHS Ex. 60 at POD 17.

<sup>16</sup> Test. of P. Mus.

<sup>17</sup> *Id.*

<sup>18</sup> DHS Ex. 61 at POD 22.

<sup>19</sup> Test. of P. Mus.

<sup>20</sup> Test. of J. Reger.

issued a Correction Order finding a number of violations (33), concerning, among other things, documentation of employment policies and procedures; failure of staff persons to sign and date client records; inappropriate use of electronic record-keeping; failure to submit completed background study forms for two staff members; failure to complete initial service plans, comprehensive assessments, and assessment summaries as required by the rules; and failure to complete and revise individual treatment plans, progress notes, and discharge summaries. The Department also fined West Metro for the background study violations.<sup>21</sup> West Metro submitted a plan to correct the violations in mid-March 2006.<sup>22</sup> DHS took no other adverse action against West Metro's license at that time.

### **Complaints of [Client 8 and Client 6]**

16. In the summer of 2006, the Department learned of two complaints from former clients alleging serious violations by West Metro. The former clients were [Client 8 and Client 6].

17. In April 2006, Lil Heiland, the clinical director of Wayside Halfway House, contacted DHS staff about [Client 8], a woman who stayed at Wayside House after leaving West Metro. Wayside is a treatment program for women who are addicted and have mental illness or sexual abuse in their background. Heiland said that [Client 8] had reported that while [Client 8] was living in the women's house and undergoing treatment at West Metro, residents were using and selling drugs in the house. In addition, [Client 8] reported that she had developed a personal, as opposed to professional, relationship with her West Metro counselor. After [Client 8] signed in for treatment, the counselor would ask [Client 8] to leave the treatment group or would call her at the house to ask [Client 8] for help with filing paperwork (drug tests, drug court papers, and discharge summaries) in other client files. While [Client 8] was doing the filing, the counselor would often ridicule other clients and staff members. When [Client 8] questioned the counselor about billing for services she was not receiving, the counselor told her that this was fair because the insurance payment helped pay for her housing. The Wayside clinical director told the licensor that she had reported these concerns to Pat Mus and Sam Stern at West Metro and to the contract compliance manager at Hennepin County, none of whom appeared to share her concerns.<sup>23</sup>

18. When [Client 6] talked to licensor Sharon Mills on July 27, 2006, he was in a detoxification facility. He said he had been in West Metro from June 22, 2006, to July 12, 2006. While undergoing treatment, he lived in one of the men's housing units. He said most of the clients at West Metro were referred through criminal diversion programs and were not interested in treatment. He said it was commonplace for people to sign in during the morning and to leave by noon, and

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<sup>21</sup> DHS Exs. 63 & 64.

<sup>22</sup> Testimony of Sharon Mills; WMRS Ex. 90.

<sup>23</sup> Ex. 17; Testimony of Lil Heiland.

some clients would take the bus downtown for the afternoon. Often 28 or more people would be in group sessions at the start of the day, with only eight or ten remaining by noon. Counselors did not write down what was going on in group sessions, and they did not know what happened in previous group sessions attended by other counselors. After a few days, [P1] told [Client 6] that [Client 6] would be helping him at the Lifetime Transitions thrift store that day instead of attending a group session. [Client 6] went with [P1] and helped move boxes at the store. In the following days, [Client 6] regularly left treatment at the request of [P1] to do various errands, such as going to the food shelf or grocery store for items needed at the sober houses. He helped do maintenance chores at the sober houses, and he did personal errands for [P1's] family members. [Client 6] estimated he went to about one third of the treatment sessions he signed in for at West Metro. He was not sure who his primary counselor was supposed to have been, but believed it was [SP3]. On July 10, 2006, West Metro informed [Client 6] that his insurance funding had not worked out as expected and that he would have to have a Rule 25 assessment and start treatment over, so that West Metro could be paid.<sup>24</sup> [Client 6] went through the Rule 25 assessment, but he was upset that he would have to start over. He left the program because he was "sick of it."<sup>25</sup>

19. On August 17, 2006, the licensor went to West Metro to investigate these complaints. She asked for the file on [Client 6], which staff members said was not available. The next day they gave her the file. It contained a sign-in sheet indicating that [Client 6] had signed in for treatment June 22 to July 12, 2006. The sign-in sheet contains notations suggesting that treatment sessions on dates from June 22 to July 20, 2006, were billed. A Rule 25 assessment dated July 10, 2006, completed by a counselor at Turning Point, contains false information that [Client 6] had recently used alcohol and makes no reference to his time at West Metro. A treatment plan dated July 13, 2006, contains signatures of [SP6] as an Alcohol and Drug Counselor-Trainee and [SP3], a Licensed Alcohol and Drug Counselor. The file contains progress notes dated August 10, 2006, reflecting treatment sessions from July 12, 2006 (the day [Client 6] left the program) through August 7, 2006. The progress notes contain the signatures of [SP6] and [SP3]. A discharge summary completed by [SP6] indicates [Client 6] was admitted July 10, 2006, discharged August 7, 2006, and completed 95 hours of treatment. The discharge summary is not dated but contains signatures of [SP6] and [SP3].<sup>26</sup>

20. During this visit, the licensor also requested the file for [Client 8]. A number of file documents (the treatment plan, weekly progress review, and discharge summary) were not contained in the client file but were stored electronically in the counselor's computer. The documents were printed, and the

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<sup>24</sup> A "Rule 25" chemical dependency assessment is required to authorize treatment for persons receiving public assistance. See Minn. R. 9530.6615.

<sup>25</sup> DHS Ex. 13; Testimony of T.H.

<sup>26</sup> DHS Ex. 21.

licensor copied them. The documents provide that [Client 8] was admitted March 16, 2005, and discharged with staff approval on July 15, 2005. Her sign-in sheets indicate she attended treatment May 27, 2005, through July 7, 2005.<sup>27</sup> In an interview, the counselor admitted that [Client 8] did do filing for her, but said [Client 8] filed only insurance and billing information and client homework. The counselor also maintained that [Client 8] did not go through client charts, but just put the documents inside the front cover of the files. The counselor denied that [Client 8] was pulled out of group sessions to do filing. The counselor said [Client 8] was not discharged from treatment but eventually “disappeared.”<sup>28</sup>

21. Based on the contents of the [Client 6] file and the complaint concerning [Client 8], the Department determined that another licensing review should be performed in November 2006 to follow up on these matters and to determine how West Metro was implementing the February 2006 correction order. In addition, DHS intended to investigate a complaint that in October 2006, a staff person employed by Lifetime Transitions had sexual contact with a client receiving treatment at West Metro.<sup>29</sup>

### **November 2006 Licensing Review**

22. The licensing review was conducted on November 9 and 13-14, 2006. In the course of the licensing review, the Department interviewed several staff members and found the following categories of violations, which did occur:

#### *Background Study Act Violations*

23. [P1] worked for West Metro for many years. On February 23, 2005, [P1] was disqualified from contact with persons served by the program on the basis of two maltreatment determinations against him, involving neglect of and failure to supervise vulnerable adults at a group home he operated separately called Wingsong Services.<sup>30</sup> Under licensing laws, recurring maltreatment of vulnerable adults is a disqualification.<sup>31</sup> The Department notified West Metro that [P1] was not permitted to have any direct contact with persons served by West Metro’s program.<sup>32</sup> “Direct contact” means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program.<sup>33</sup>

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<sup>27</sup> DHS Ex. 26; Testimony of Sharon Mills.

<sup>28</sup> DHS Ex. 11. This document is dated August 17, 2007, but the ALJ believes this is a typographic error and the interview took place during the licensor’s visit on August 17, 2006.

<sup>29</sup> There is no further reference to this complaint in the record. In August 2006, however, [Client 8’s] treatment counselor disclosed to the licensor that [Client 8] was having a sexual relationship with an employee of Lifetime Transitions while she was living in the women’s house.

<sup>30</sup> DHS Ex. 59.

<sup>31</sup> See Minn. Stat. §§ 245C.15, subd. 4(b)(2); 245C.02, subd. 16.

<sup>32</sup> WMRS Ex. 91.

<sup>33</sup> Minn. Stat. § 245C.02, subd. 11.

24. After he was disqualified, [P1] became an employee of Lifetime Transitions. He continued, however, to have regular direct contact with persons in treatment at West Metro. In November 2006, licensors observed [P1] working in an office at West Metro; [P1] admitted to having some contact with clients in treatment; and clients of West Metro told licensors that [P1] provided them with referrals to mental health and medical appointments.<sup>34</sup> West Metro admitted in the course of this proceeding that [P1] had direct contact with persons served by the program.<sup>35</sup>

25. [SP4] was an alcohol and drug counselor at West Metro. He was hired on or about March 17, 2006. At the time he was hired, West Metro was aware (because [SP4] had been previously employed there from 1995 to 2000) that [SP4] had a disqualification based on a conviction of felony harassment in August 1995. On April 4, 2005, West Metro requested that DHS issue a variance permitting [SP4] to work there, offering to accept responsibility for supervising [SP4] and to have him meet with a therapist on a monthly basis if the variance were granted.<sup>36</sup> On April 24, 2006, DHS notified [SP4] and West Metro of the disqualification, and [SP4] requested reconsideration. DHS notified West Metro that while the reconsideration request was pending, [SP4] would be permitted to have direct contact with clients only if he was under continuous, direct supervision.<sup>37</sup> "Continuous, direct supervision" means an individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of persons served by the program.<sup>38</sup> On September 15, 2006, DHS notified West Metro that [SP4's] disqualification had been set aside.<sup>39</sup>

26. DHS reviewed client files showing that between May and August 2006, [SP4] provided treatment services and signed treatment plans and progress reports, with no indication that he was being supervised by anyone.<sup>40</sup> [SP2], the counselor supervisor, told DHS staff that he met with [SP4] on a regular basis or as needed, as he does with all counselors. [SP2] said he did not sit in on group sessions or individual client meetings with [SP4] during the period in which continuous, direct supervision was required.<sup>41</sup> [SP2] admitted that no one at West Metro ever told him that [SP4] was disqualified; he was just told to supervise [SP4] as he would other counselors.<sup>42</sup>

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<sup>34</sup> DHS Exs. 10, 16, 18; Testimony of [Client 6]; Testimony of Cheyenne Drogsvold.

<sup>35</sup> DHS Ex. 69.

<sup>36</sup> WMRS Ex. 123.

<sup>37</sup> DHS Ex. 19.

<sup>38</sup> Minn. Stat. § 245C.02, subd. 8 (2006).

<sup>39</sup> DHS Ex. 19.

<sup>40</sup> DHS Exs. 20, 34, 44, 46.

<sup>41</sup> DHS Ex. 6.

<sup>42</sup> Testimony of [SP2].

27. West Metro hired [SP15] to be a drug and alcohol counselor in June or July 2006. West Metro failed to submit a background study request for [SP15] until after licensors reviewed his file.<sup>43</sup>

*Submission of False and Misleading Information to the Commissioner During an Investigation*

28. The Commissioner may suspend or revoke a license, or impose a fine, if a license holder knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable law or rules.<sup>44</sup>

29. West Metro hired [SP6] on April 28, 2006. [SP6] had a temporary permit to work as an Alcohol and Drug Counselor—Trainee. West Metro's counselor supervisor, [SP2] was responsible for supervising [SP6's] work. The terms of the permit issued by the Board of Behavioral Health and Therapy required that [SP6] be at all times under the direct supervision of a licensed Alcohol and Drug Counselor.<sup>45</sup>

30. When DHS staff returned to West Metro in November 2006, the documents the licensor had copied from the [Client 6] file in August were missing. [SP5], the admissions counselor, said the documents were probably misfiled. When asked to explain the different dates in the various file documents copied by the licensor, she said that West Metro provided housing to [Client 6] until his funding went through, as it did for many others, and that no admissions paperwork was typically done until the treatment was funded. West Metro called this "guest status." While on guest status, people could choose to attend group treatment sessions but were not required to do so. She said people on guest status were aware they were guests and not formally in treatment.<sup>46</sup>

31. DHS staff interviewed [SP3] about the documents in [Client 6's] file. [SP3] denied that the signatures in the file were his. He showed the licensor an example of his signature on another document, and it did not match the signature in the [Client 6] file. [SP3] said the signature looked like it was written by [SP5], West Metro's admissions counselor.<sup>47</sup>

32. When DHS staff interviewed [SP6] about the documents in [Client 6's] file on November 14, 2006, [SP6] first said he could not remember [Client 6] and could not explain all of the different dates on the treatment plan, progress

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<sup>43</sup> Test. of C. Drogsvold. The completed background study showed no disqualifications.

<sup>44</sup> Minn. Stat. § 245A.07, subd. 3.

<sup>45</sup> DHS Exs. 22, 24.

<sup>46</sup> DHS Ex. 12; Test. of S. Mills.

<sup>47</sup> DHS Ex. 8; Test. of S. Mills.

notes, and discharge summary.<sup>48</sup> When the licensor later went to Pat Mus for an explanation, he told her that [SP6] had been behind in his charting and had falsified the dates because he was scared and nervous about how licensors would react.<sup>49</sup> He said that [SP6] had been fired immediately for his conduct. With regard to [Client 6], Mus said that [Client 6] was on “guest status” starting June 22, 2006. Mus said no one admitted to signing [SP3’s] name on the documents. He indicated that the problem with the start date happens because Rule 25 assessors do not always turn in their paperwork promptly.<sup>50</sup>

33. In subsequent conversations with DHS staff, [SP6] said that when the licensor had first requested the [Client 6] file [in August], [SP2] had brought the file to [SP6] and told him to “fix” the file. When [SP6] told [SP2] he did not know who [Client 6] was, [SP2] told him to “make up” whatever information he needed to complete the file documentation. [SP6] fabricated the documents and gave the file to [SP2] when it was completed. [SP6] did not sign [SP3’s] name to the documents. When Pat Mus fired [SP6] on November 14, 2006, he told [SP6] that he could continue to work as a house manager for Lifetime Transitions at the same pay, but that he should stay away from West Metro for the next few days while licensors were there. [SP6] said there were so many people coming in and out of West Metro that it was difficult to keep track of what was going on in group. People routinely left group sessions without signing out, “they were running all over.” He said people showed up in treatment sessions for weeks before they got funding, and confidentiality was a problem. He described the philosophy of West Metro as “[g]et as many clients as you can from anywhere you can.”<sup>51</sup> [SP6] also said [SP2] did not supervise his work under the temporary permit by attending any counseling sessions or reviewing his treatment documents.<sup>52</sup>

#### *False and Misleading Information in Client Files*

34. West Metro uses the treatment sign-in sheets in each client’s file to document client attendance at treatment sessions. The sign-in sheets are also used for purposes of billing insurance companies or other payment sources.<sup>53</sup> The sign-in sheets contain the client’s name at the top, below which the client is required to fill in the date, a signature, and a statement whether the client remains clean and sober or is attending A.A. There is no space on the form to indicate how long a client was in treatment each day or whether a client has left a treatment session before the end of the day.<sup>54</sup>

35. When DHS staff interviewed [Client 8] on November 21, 2006, she said she was at West Metro from November 2004 through January 2005, when

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<sup>48</sup> DHS Ex. 5.

<sup>49</sup> DHS Ex. 9.

<sup>50</sup> *Id.*

<sup>51</sup> DHS Ex. 5; Testimony of [SP6].

<sup>52</sup> DHS Ex. 5; Test. of [SP6].

<sup>53</sup> Testimony of [SP9].

<sup>54</sup> See, e.g., DHS Ex. 25.

she moved out for one month. She returned and was there from March through August 2005. She was in the Intensive Outpatient Program with 19 other women. She described the counselor, [SP9], as being overwhelmed because of the size of the group. [Client 8] said she did the requested filing of urinalysis results, drug court information, and discharge summaries two to three times a week for about one month. She said that in July 2005, she got a job and started working at a coffee shop during the day. She said her counselor told her to come and sign into the group session each morning before she went to work. The counselor said [Client 8] had to do that so West Metro would get paid for her housing. [Client 8] said the counselor and Pat Mus were angry when [Client 8] decided to move out after she received her first paycheck. Mus called her and encouraged her to apply for emergency funds from Hennepin County to pay for Lifetime Transition housing, which [Client 8] refused to do.<sup>55</sup>

36. West Metro staff instructed both [Client 6] and [Client 8] to sign in to group treatment sessions that West Metro knew [Client 6] and [Client 8] were not attending.

#### *Provision of Treatment Services to Persons Who Were Not Clients*

37. DHS rules define “client” as an individual accepted by a license holder for assessment or treatment of chemical use problems.<sup>56</sup> Client status triggers a number of obligations for license holders. Before any treatment is provided, the license holder must develop an initial service plan for a client, identifying the client’s immediate health, safety, and preliminary service needs.<sup>57</sup> Upon initiation of service, clients must be given a written statement of client rights and responsibilities, and the license holder must explain the grievance procedures.<sup>58</sup> Comprehensive assessments, assessment summaries, and treatment plans must be developed within a certain number of days of service initiation.<sup>59</sup>

38. In addition to [Client 6’s] file, three other client files (out of eight files reviewed in the survey) reflected that clients signed in for treatment, sometimes days or weeks before they were admitted to the program.<sup>60</sup> West Metro’s Admissions Counselor told the Department that this happened approximately four to five times per month, with the numbers tending to increase in the colder months.<sup>61</sup> In the course of this proceeding West Metro admitted it

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<sup>55</sup> DHS Ex. 14.

<sup>56</sup> Minn. R. 9530.6405, subp. 8.

<sup>57</sup> Minn. R. 9530.6420.

<sup>58</sup> Minn. R. 9530.6470, subps. 1 & 2.

<sup>59</sup> Minn. R. 9530.6422, 9530.6425.

<sup>60</sup> DHS Ex. 21 ([Client 6] started attending treatment 6/22/06, admit date identified as 7/10/06); Ex. 25 at DHS 285, Ex. 68 at DHS 102a ([Client 1] started attending treatment 10/12/06, admit date identified as 10/17/06); DHS Ex. 25 at DHS 283, DHS 41 ([Client 3] started attending treatment 10/19/06, placed at West Metro for treatment 10/24/06); DHS Ex. 25 at DHS 284, Ex. 36 ([Client 2] started treatment 10/24/06, placed for treatment 11/2/06).

<sup>61</sup> DHS Ex. 12.

provided services to individuals who were not clients until the Department instructed it to stop in November 2006.<sup>62</sup>

### *Operating as a Residential Program without Residential Licensure*

39. Under DHS rules, a license holder may provide room, board, and supervision at a treatment site to give the client a safe and appropriate environment in which to gain and practice new skills.<sup>63</sup> A license holder who provides supervised room and board at the licensed program site as a treatment component is defined as a residential program under Minn. Stat. § 245A.02, subd. 14.<sup>64</sup> License holders who provide these services must also have a health facility license from the Department of Health.<sup>65</sup>

40. West Metro maintains that it does not provide room, board, or supervision of persons undergoing treatment, but that Lifetime Transition Services, as a separate entity, provides food and sober housing, for which no license is required. But employees of Lifetime Transition Services used office space at West Metro,<sup>66</sup> did maintenance for West Metro's building and grounds and had access to West Metro's client files, provided meals to clients at West Metro, stored and dispensed medications to clients from an office in West Metro,<sup>67</sup> staffed the front desk at West Metro when needed, and provided transportation from sober housing locations to treatment.<sup>68</sup> Treatment staff at West Metro frequently referred to the Intensive Outpatient Program with Housing as "WMRS housing."<sup>69</sup> Two clients said they were told by West Metro staff that they were receiving residential treatment services.<sup>70</sup>

41. Lifetime Transition required its clients to sign a document called "House Rules—No Exceptions." The document then provides that "[West Metro] sets your program and your rules. Talk to them if you disagree with them, do not talk to the house manager." The House Rules prohibit residents from leaving the house or making any outgoing phone calls in the first week of treatment and require residents to get a pass from their treatment counselor after the first week for permission to leave the house, for overnights, or for additional phone time; to

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<sup>62</sup> DHS Ex. 69.

<sup>63</sup> Minn. R. 9530.6430, subp. 2 H.

<sup>64</sup> Minn. R. 9530.6505, subp. 1.

<sup>65</sup> *Id.*, subp. 4.

<sup>66</sup> DHS Ex. 56.

<sup>67</sup> DHS Ex. 15.

<sup>68</sup> DHS Ex. 69.

<sup>69</sup> DHS Ex. 67 at DHS 84; Ex. 51 (progress note); Ex. 40 (progress note). See also WMRS Ex. 120 (memo to West Metro staff regarding visit by county to audit contract compliance, may be touring "WMRS housing," please advise clients to keep housing presentable); WMRS Ex. 111 (West Metro letter to Hennepin County referring to "WMRS IOP housing"); WMRS Ex. 28 (post-revocation letter of support from client providing "I'm currently doing inpatient care at West Metro").

<sup>70</sup> Testimony of [Client 6]; DHS Ex. 15.

obtain permission from their counselor in order to sign in and out; and to pack their own lunch for treatment.<sup>71</sup>

*Failure to Protect Client Records from Loss, Tampering, or Unauthorized Disclosure*

42. Client records must be protected against loss, tampering, or unauthorized disclosure in compliance with Minn. Stat. § 254A.09 and 42 C.F.R. §§ 2.1 to 2.67.<sup>72</sup> Written records pertaining to clients must be maintained in a secure room, locked file cabinet, safe or other similar container when not in use, and each program shall adopt written procedures regulating access to and use of written client records.<sup>73</sup>

43. West Metro allowed the unauthorized disclosure of client records to [Client 8] when she filed client documents for her counselor.<sup>74</sup>

44. Counselors at West Metro stored client files in unlocked filing cabinets and on open bookshelves. The counselor supervisor's office was left open and unlocked on two occasions when DHS staff was visiting. An employee of Lifetime Transitions who cleaned the West Metro building had keys to counselors' offices, which could permit him to obtain access to files in unlocked cabinets.<sup>75</sup>

*Violations Concerning Program Policies and Procedures*

45. A license holder must have a written procedure approved by a licensed physician for obtaining medical interventions when needed for any client.<sup>76</sup> West Metro did not have physician-approved policies and procedures for obtaining medical intervention when needed for any client.<sup>77</sup> West Metro was previously cited for this same violation in the February 2006 Correction Order.

46. West Metro's policies and procedures provide that it would not store or dispense medications at its facility.<sup>78</sup> After [Client 10] was released from the hospital in November 2006, her medications (including medication for blood pressure and diabetes, Vicodin, and nitroglycerin) were stored in an office at

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<sup>71</sup> DHS Ex. 38.

<sup>72</sup> Minn. R. 9530.6440, subp. 1.

<sup>73</sup> 42 C.F.R. § 2.16.

<sup>74</sup> DHS Exs. 11 & 14.

<sup>75</sup> Test. of C. Drogsvold.

<sup>76</sup> Minn. R. 9530.6435, subp. 2.

<sup>77</sup> Test. of S. Mills.

<sup>78</sup> DHS Ex. 28. If it intended to administer or dispense medications to clients, West Metro would have to comply with a variety of rules requiring development of policies and procedures and supervision of staff by a registered nurse, and it would have to document staff training and competence with regard to those procedures. See Minn. R. 9530.6435, subp. 3.

West Metro. The house manager for Lifetime Transitions dispensed a daily supply of the medications from that office.<sup>79</sup>

#### *Violations Concerning the Client Treatment Process and Documentation*

47. Counseling groups are to have on average no more than 16 clients per group session.<sup>80</sup> Two clients and one counselor reported that during the summer of 2006, there were generally 20 persons in the women's group with one counselor, and there were 28 to 30 persons in the men's group with one counselor, before the group dispersed in the afternoons.<sup>81</sup> When a DHS licenser entered the men's group on the afternoon of November 9, 2006, there were ten men in attendance, but the roster indicated 22 persons had signed in earlier. West Metro staff persons told the licenser that the missing people could have been at appointments or running errands. At no time did West Metro staff indicate that the missing people were participating in smaller "break-out" sessions elsewhere in the building.<sup>82</sup>

48. Before the first treatment session, license holders must develop the client's initial service plan.<sup>83</sup> Within three days, a counselor must coordinate and complete a comprehensive assessment; within three treatment sessions, an assessment summary must be prepared containing information relevant to treatment planning.<sup>84</sup> Individual treatment plans must be reviewed and revised during the course of treatment; the plans must include the specific methods to be used to address identified problems, including the amount, frequency, and anticipated duration of treatment service.<sup>85</sup> Progress notes must be entered weekly or after each treatment service, whichever is less frequent, by the staff person providing the service. Treatment plans must be reviewed at least weekly. All entries in a client's record must be legible, signed, and dated. Late entries must be clearly labeled "late entry," and corrections must be made in a way in which the original entry can still be read.<sup>86</sup>

49. DHS staff reviewed eight client files. They found many violations concerning documentation of the treatment process, most of which were cited previously in the February 2006 Correction Order. Each of the eight files lacked an Initial Service Plan.<sup>87</sup> More importantly, the "Intake Assessment Forms" used by West Metro were not signed or dated by anyone, and it is not clear who filled

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<sup>79</sup> DHS Ex. 15.

<sup>80</sup> Minn. R. 9530.6445, subp. 4.

<sup>81</sup> DHS Exs. 5, 13, 15.

<sup>82</sup> Test. of C. Drogsvold.

<sup>83</sup> Minn. R. 9530.6420.

<sup>84</sup> Minn. R. 9530.6422.

<sup>85</sup> Minn. R. 9530.6425, subps. 1 & 2.

<sup>86</sup> *Id.*, subp. 3.

<sup>87</sup> DHS Ex. 21; DHS Ex. 26; DHS Ex. 27; DHS Ex. 36; DHS Exs. 40, 42-43, 67; DHS Ex. 41; DHS Ex. 68.

them out.<sup>88</sup> The “Intake Assessment Forms” did not meet the requirements of the rule concerning comprehensive assessments or summaries, because they failed to seek information concerning client sexual orientation, previous attempts to treat compulsive gambling, ability to understand written treatment materials, and information about risk-taking behavior. In those cases in which the forms did seek required information, the questions were often answered in an incomplete manner.<sup>89</sup> The forms did not seek information as to whether a client has the characteristics of a vulnerable adult, nor is there a determination by a staff person as to whether the client is or is not a vulnerable adult who requires an abuse prevention plan.<sup>90</sup>

50. None of the treatment plans appeared to have been updated or revised during the course of treatment, even when progress notes showed that clients had multiple relapses. Seven of the eight treatment plans reviewed failed to include the amount and frequency of treatment services or identify the goals the client must reach to complete treatment and have services terminated. Nor did the treatment plans provide for the involvement of family members or other persons important to the success of the client’s treatment. Some of the treatment plans were incomplete, and were not dated by the client or the counselor.<sup>91</sup> In addition, progress notes did not identify the amount of each treatment service provided. Some progress notes were incomplete, and some were untimely.<sup>92</sup> Discharge summaries were sometimes missing or failed to include required information.<sup>93</sup>

#### *Violations Concerning Staff Qualifications and Training*

51. Alcohol and drug counselors must be licensed or exempt from licensure under Minnesota Statutes, chapter 148C.<sup>94</sup> One staff member ([SP6]) hired to be a counselor in April 2006 was unlicensed, and he did not receive a temporary permit to work under the supervision of a licensed counselor until September 2006. Nonetheless, during the summer of 2006, he worked as a counselor, without the permit and without the supervision required by the permit that was later obtained.<sup>95</sup> Another staff member, [SP10], had no license in his personnel file; licensors subsequently determined his license had expired in

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<sup>88</sup> DHS Ex. 21 at DHS 115-20; DHS Ex. 26 at 146-51; DHS Ex. 27 at DHS 270-75; DHS Ex. 36 at DHS 234-39; DHS Ex. 41 at DHS 259-64; DHS Ex. 68 at DHS 93-98.

<sup>89</sup> *Id.*

<sup>90</sup> *Id.*

<sup>91</sup> DHS Ex. 21 at DHS 125; DHS 26 at DHS 143-44; DHS Ex. 27 at DHS 276; DHS Ex. 36 at DHS 240-41; DHS Ex. 41 at DHS 242; DHS Ex. 42; DHS Ex. 68 at DHS 99.

<sup>92</sup> DHS Ex. 21 at DHS 122-24; DHS Ex. 26 at DHS 140; DHS Ex. 27 at 277-79; DHS Ex. 41 at DHS 244-45; DHS Ex. 67; DHS Ex. 68 at DHS 101-02.

<sup>93</sup> DHS Ex. 26 at DHS 141; DHS Ex. 27; DHS Ex. 43.

<sup>94</sup> Minn. R. 9530.6450, subp. 5.

<sup>95</sup> DHS Exs. 22 & 24.

March 2006, four months before he was hired in July 2006, and it was still expired at the time of the survey.<sup>96</sup>

52. Treatment programs are required to document the qualifications and training of staff in the staff member's personnel file, along with documentation related to the completion of background studies.<sup>97</sup> Some of West Metro's personnel files (four or five out of nine reviewed) lacked copies of current licenses, employment applications, and confirmation that an inquiry was made with past employers regarding any substantiated sexual contact with a client.<sup>98</sup> In addition, the one staff person who was certified to provide first aid and CPR was not available at all times when clients were on the premises.<sup>99</sup> The files also lacked documentation that staff members were free from chemical use problems for the required period of time prior to being hired, that they had gone through an appropriate orientation process, were trained on the drug and alcohol policy, or had received training on any of the topics required by the rules (including reporting requirements for maltreatment of vulnerable adults and children, the program's abuse prevention plan, and policies for obtaining client releases of information).<sup>100</sup> Many of these violations were previously cited in the February 2006 Correction Order.<sup>101</sup>

#### *Violations Concerning Client Rights and Responsibilities*

53. Upon initiation of service, license holders must give each client a written statement of client's rights and responsibilities, and staff must review the statement with the client at that time. License holders must also explain the grievance procedure to clients, and the grievance procedure must require that staff help clients develop and process a grievance, disclose telephone numbers and contact information for licensing authorities, and obligate license holders to respond to a grievance within three days of receipt.<sup>102</sup>

54. Of the eight files reviewed, none contained documentation to show that staff reviewed information with clients regarding client rights or the grievance procedure. The files contained only a statement that clients acknowledged receiving and reading these procedures, among others, "and have been given assurance that further explanation will be given during treatment if I so request."<sup>103</sup>

55. Federal law controls the form of written consent to disclose client information. A valid consent must include the name of the person or organization

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<sup>96</sup> DHS Ex. 23. The license was renewed in December 2006. See WMRS Ex. 104.

<sup>97</sup> Minn. R. 9530.6460, subp. 3.

<sup>98</sup> DHS Ex. 1 at DHS 17; DHS Exs. 22 & 24.

<sup>99</sup> DHS Ex. 1 at DHS 18.

<sup>100</sup> DHS Ex. 1 at DHS 18-19.

<sup>101</sup> DHS Ex. 63.

<sup>102</sup> Minn. R. 9530.6470, subps. 1 & 2.

<sup>103</sup> See, e.g., DHS Ex. 21 at DHS 133.

to which disclosure is to be made, the purpose of the disclosure, the type of information to be disclosed, and a variety of other information.<sup>104</sup>

56. Some of the client files contained releases that did not specify to whom the data would be released, what type of information would be released, or the purpose for which the information would be used.<sup>105</sup>

#### *Violations Concerning Knowledge of the Rules*

57. The rules require that program treatment directors and supervisors know and understand the implications of the rules and statutes governing chemical dependency treatment.<sup>106</sup> West Metro was cited under this provision based on the nature, chronicity, and severity of the violations found.

58. A license holder who intends to use electronic recordkeeping must first obtain written permission from the commissioner. The Commissioner must grant permission after the license holder provides documentation demonstrating the license holder's use of a system for ensuring the security of electronic records.<sup>107</sup> The Department cited West Metro for violating this rule in February 2006, and as of November 2006 West Metro was still using electronic recordkeeping without obtaining written permission from the Commissioner.<sup>108</sup>

59. On November 14, 2006, DHS Licensors met with West Metro regarding their findings. The Licensors informed West Metro that there is no such thing as "guest status" in a treatment program; either people are clients, or they are not. Those who are not clients cannot attend treatment or be present while clients are being treated. Licensors informed West Metro about the required revisions to employee files and client files, the need to standardize treatment plans, the need to include the amount and frequency of services and goals on treatment plans, and the need to revise treatment plans appropriately during the course of treatment. They went over the need for dates and signatures on client records and the obligation to maintain the confidentiality of client files.<sup>109</sup>

60. On November 20, 2006, West Metro submitted a request to use electronic recordkeeping, maintaining its system was adequate to ensure the

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<sup>104</sup> 42 U.S.C. § 2.31.

<sup>105</sup> DHS Ex. 35 at DHS 174; DHS Ex. 36 at DHS 229.

<sup>106</sup> Minn. R. 9530.6450, subps. 3 & 4.

<sup>107</sup> Minn. R. 9530.6440, subp. 4.

<sup>108</sup> DHS Ex. 1 at 20. Pursuant to this requirement, license holders may not store information electronically without the commissioner's advance permission. License holders may use computers to generate documents in the first instance, but the documents must be printed, signed, and stored in the client's file. See generally Ex. 45.

<sup>109</sup> WMRS Ex. 116.

security of electronic records.<sup>110</sup> The Department denied this request on February 12, 2007.<sup>111</sup>

## **Revocation Orders**

61. On April 27, 2007, the Department issued an Order of Revocation, based on the violations described above.<sup>112</sup> The Revocation Order described each violation and concluded that the number and serious nature of the licensing violations posed an unacceptable risk of harm to persons receiving services from the program and warranted revocation of the license.<sup>113</sup>

62. On May 4, 2007, West Metro responded in writing to the Revocation Order. West Metro took little responsibility for the cited violations. It denied knowledge of the fabrication of [Client 6's] file; maintained that [Client 8] and [Client 6] were lying about the matters in their complaints; and argued that the disqualification of [P1] was inapplicable to his employment at Lifetime Transitions. West Metro also contended that there was nothing wrong with Lifetime Transitions personnel using West Metro offices because Lifetime Transitions was a separate entity. It incorrectly maintained that [SP4] was disqualified only because of a DHS mistake, and it argued that the counselor hired without a current license had misled West Metro about his licensed status. West Metro offered to retain outside trainers to work with staff to avoid the problems alleged with regard to treatment plans, progress notes, and discharge summaries, "to the extent [the alleged problems] actually exist." It maintained that it had changed its policies and reviewed all personnel files to make the required corrections. With regard to the allegation that it failed to have a licensed physician approve its procedures for medical intervention, it maintained:

The medical procedures were approved by Dr. Steven Pratt, Medical Director of UBH. Dr. Pratt worked directly with Park Avenue Center, another Rule 31 provider. WMRS, Park Avenue Center and other providers worked together to prepare procedures to comply with Rule 31. WMRS utilized the procedures signed off on by Dr. Pratt. WMRS is willing to meet directly with Dr. Pratt, if necessary, to have him re-approve the procedures.<sup>114</sup>

63. In May 2007, West Metro updated its policies and procedures. It developed new sign-in sheets and sent a variety of memos to counseling staff regarding weekly reviews of files and supervision of interns.<sup>115</sup>

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<sup>110</sup> DHS Ex. 45.

<sup>111</sup> DHS Ex. 45.

<sup>112</sup> DHS Ex. 1.

<sup>113</sup> DHS Ex. 1 at 20.

<sup>114</sup> DHS Ex. 56 at DHS 25.

<sup>115</sup> WMRS Exs. 87, 129, 83, 127, and 130.

64. On May 15, 2007, Dr. Steven Pratt wrote to DHS stating that when he worked with Park Avenue Center, he had no intention of creating a universal policy and procedure that could be implemented at any facility. He said he had no contact with West Metro, had never visited the facility, and had no knowledge of West Metro's ability to implement policies or oversee medical needs of participants in West Metro's program. He said the implication that West Metro had a policy approved by UBH "is highly inappropriate" and that he had no intention of approving any policy or having any affiliation with West Metro.<sup>116</sup>

65. In late May or early June 2007, a former client of West Metro contacted DHS and provided to DHS approximately 12 West Metro client files that he said were taken from several boxes of files being stored in an unlocked, unsupervised weight room at one of the sober houses in Coon Rapids. The files contained financial information, Social Security numbers, treatment plans, discharge summaries, and other treatment-related client documents. The former client also provided to DHS a series of photographs of the weight room, showing boxes of files stored in one corner, as well as photographs of Lifetime Transitions staff members and others carrying the boxes from the weight room out to a fire pit on the property and burning the files in the fire pit.<sup>117</sup> The photographs depict boxes of files stacked next to the fire pit, and documents are scattered on the ground around the fire. Some of the photographs are dated "5 9 '07" by the camera. The photos were clearly taken in warm weather—the grass is green, dandelions are in bloom, and the men in the photographs are wearing shorts and short-sleeve or sleeveless t-shirts.<sup>118</sup>

66. On June 13, 2007, DHS licensors returned to West Metro to obtain more information about how a West Metro client had obtained these documents. When questioned about his document destruction policies for client records, Pat Mus told investigators that records of discharged clients are stored for seven years in a locked file room in West Metro's basement. When asked about the burning of client files, Mus said he had burned old client files on two occasions in the fire pit in Coon Rapids. He said on these occasions he would load boxes of files that were old enough to be destroyed into his truck, drive to Coon Rapids, back his truck up to the fire pit, unload the boxes, and burn them. He said that house manager [P3] had helped him, but no clients of West Metro were involved. The first occasion when files were burned was approximately January 2006, and the second occasion was in the end of March or the beginning of April 2007.<sup>119</sup> When DHS staff questioned [P3], the Coon Rapids house manager, [P3] first denied that he had ever participated in burning any client files. When confronted with the photographs, he said it could have happened on May 9, 2007, but he could not remember the exact day.<sup>120</sup>

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<sup>116</sup> DHS Ex. 37.

<sup>117</sup> DHS Ex. 58; Test. of C. Drogsvold.

<sup>118</sup> DHS Ex. 58.

<sup>119</sup> WMRS Ex. 102.

<sup>120</sup> WMRS Ex. 99.

67. On July 30, 2007, the Department issued an Amended Order of Revocation adding to the reasons for revocation the allegation that Pat Mus had provided false information in connection with an investigation of the burning of the files, and that West Metro had failed to protect the client records against unauthorized disclosure.<sup>121</sup>

68. On October 18 and 22, 2007, the Department returned to West Metro to conduct a licensing review. It found the following violations, which did occur:

*False and Misleading Information in Client Files*

69. Counselor supervisor [SP2] told DHS staff that a [Client 15] was admitted to the program on August 23, 2007, but the supervisor was unable to complete the treatment plan on that date. He said that he completed the treatment plan on August 27, 2007, at which time the client signed it. A discharge summary dated September 4, 2007, indicates [Client 15] was discharged for leaving the program without permission after completing five sessions. There are several versions of the same progress notes, one of which provides that [Client 15] left the program before the treatment plan was completed. The client was re-admitted on October 1, 2007; it appears the October 1 date was written on the treatment plan, then crossed off and replaced with the date August 27, 2007.<sup>122</sup>

70. During the visit, a DHS licensor asked to see the progress notes for a different client, [Client 13], and [SP2] (who was not at the facility that day) told the licensor by telephone that the notes were not in the file but were stored on his computer, which was locked in his office. The next day, he faxed to the licensor some handwritten progress notes.<sup>123</sup> [SP2] maintained he was wrong about the notes being on his computer, and the notes were actually sitting on his desk. [SP2] denied storing any client records electronically. All other progress notes in this record that are written by [SP2] appear to have been written initially on a computer, with handwritten notations appearing for some subsequent dates.<sup>124</sup>

*Violations Concerning the Client Treatment Process and Documentation*

71. The Department reviewed five client files. Three had violations concerning the initial service plan (two were missing and one was created approximately two months after the client was admitted to the program).<sup>125</sup> The Comprehensive Assessments were not dated or signed and appear to have been

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<sup>121</sup> DHS Ex. 2.

<sup>122</sup> DHS Ex. 31 at DHS 562.

<sup>123</sup> DHS Ex. 32 at DHS 527-29.

<sup>124</sup> See DHS Ex. 31, 51.

<sup>125</sup> DHS Ex. 30; DHS Exs. 33 and 46; DHS Exs. 31 and 50.

completed by the clients.<sup>126</sup> All of the Comprehensive Assessment forms were incomplete in some regard; all were missing the client's age, and some were missing other information such as sexual orientation, economic status, gender, economic status, previous attempts at treatment, periods of abstinence, or physical concerns. Although some of the forms ask the required questions to determine whether the client is a vulnerable adult, there is nothing to indicate that a staff person has reviewed the responses and concluded one way or another whether the client is or is not a vulnerable adult.<sup>127</sup> The Assessment Summaries are undated and unsigned and do not incorporate treatment planning information in the manner required by the rules (using the six dimensions).<sup>128</sup>

72. In addition, there were a number of deficiencies with regard to treatment plans. None appeared to have been revised or updated as clients progressed through treatment, and none of them included the amount, frequency, and anticipated duration of treatment services. They did not document the goals the client must reach to complete treatment and have services terminated. Several were not signed by the client or counselor, and three did not document the involvement of a family member or support person.<sup>129</sup> Progress notes for one client were not available at the time of the review, and another set was incomplete.<sup>130</sup> One client signed in for treatment on many days that are not reflected in the progress notes (February 22 through March 5, 2007), and, conversely, there are progress notes indicating the client was present in treatment on days when he did not sign into treatment.<sup>131</sup> The client consistently answered "no" to the question whether he was attending A.A. meetings; the progress notes provide, however, that this client was attending A.A. meetings.<sup>132</sup> In addition, there are significant gaps in the client's attendance at treatment sessions (most notably between May 2 and May 21, 2007), and there is no reference or explanation in the progress notes for his failure to attend during this period. None of the files contained weekly treatment plan reviews.<sup>133</sup>

73. Four of the five files reviewed contained documents that were not signed by the person who wrote them, including progress notes, assessments, and discharge summaries.<sup>134</sup>

74. Some of the files still reflected deficient practices with regard to client consent forms—the form was signed in blank, without indicating the person

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<sup>126</sup> DHS Ex. 30 at DHS 495-509; DHS Ex. 32 at DHS 518-26; DHS Exs. 47 & 50; DHS Ex. 51 at DHS 457-65.

<sup>127</sup> *Id.*

<sup>128</sup> DHS Exs. 30 at DHS 498-509; DHS Ex. 32 at DHS 531-536; DHS Ex. 48; DHS Ex. 51 at DHS 466-71.

<sup>129</sup> DHS Exs. 31 at 560-61; DHS Ex. 32 at DHS 530; DHS Ex. 49; DHS Ex. 51 at DHS 483-84.

<sup>130</sup> DHS Ex. 32 at DHS 528; Test. of J. Reger, C. Drogsvold. See *also* DHS Ex. 51.

<sup>131</sup> Compare DHS Ex. 33 with DHS Ex. 34.

<sup>132</sup> *Id.*

<sup>133</sup> DHS Exs. 31, 32, 49, 51.

<sup>134</sup> DHS Exs. 30 at DHS 486-92 (progress notes not signed as written); Ex. 34 at DHS 552 (same); Ex. 47- 49 (assessment);

to whom information would be released, the type of information to be released, or the purpose for which information would be released.<sup>135</sup>

75. As noted above, in February 2007 the Department denied West Metro permission to store client records electronically because of concerns regarding security of the records. At the time of the review in October 2007, one counselor was storing progress notes for [Client 12] on a flash drive. The counselor said she did not know a flash drive was a form of electronic storage.<sup>136</sup> In addition, [SP2] was electronically storing the progress notes for [Client 13], which Evans wrote out by hand the next day and faxed to DHS.

#### *Violations Concerning Staff Qualifications and Training*

76. Staff members with direct client contact must be free from chemical use problems for at least one year immediately preceding their hiring and must sign a statement attesting to that fact.<sup>137</sup> The documentation of compliance with this rule must be maintained in the personnel file for each staff member.<sup>138</sup> In two personnel files, there were statements that the staff persons had no current chemical use problems, but the statements did not include the required timeframe.<sup>139</sup>

#### *Violations Concerning Program Policies and Procedures*

77. Several of West Metro's personnel policies failed to comply with rule requirements. The organizational chart and list of designated persons responsible for treatment services were outdated and included persons no longer employed there; and some of the information regarding HIV minimum standards was out of date, as was the abuse prevention plan.<sup>140</sup>

78. Based on the violations found in October 2007, DHS issued a Second Amended Revocation Order on November 28, 2007.<sup>141</sup>

Based upon these Findings of Fact, the Administrative Law Judge makes the following:

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<sup>135</sup> DHS Exs. 30, 51 at DHS 485; Ex. 52, 53.

<sup>136</sup> DHS Ex. 30 at DHS 486-92; Testimony of Julie Reger.

<sup>137</sup> Minn. R. 9530.6450, subp. 1 B.

<sup>138</sup> Minn. R. 9530.6460, subp. 3.

<sup>139</sup> DHS Ex. 39 at DHS 448-49. The statements refer to the old rules for outpatient programs, which were repealed in January 2005.

<sup>140</sup> DHS Ex. 39 at DHS 424 (organizational chart); *id.* at DHS 450 (designated staff persons responsible for treatment); *id.* at DHS 421(HIV); *id.* at DHS 440 (abuse prevention plan reviewed 12/22/04).

<sup>141</sup> DHS Ex. 3.

## **CONCLUSIONS**

1. The Commissioner and the Administrative Law Judge have jurisdiction in this matter pursuant to Minn. Stat. §§ 14.50 and 245A.08 (2006).

2. The Department gave proper notice of the hearing and all relevant procedural requirements of law or rule have been fulfilled.

3. At a hearing regarding a licensing sanction, the Commissioner may demonstrate reasonable cause for action taken by submitting statements, reports, or affidavits to substantiate the allegations that the license holder failed to comply fully with applicable law or rule. If the Commissioner demonstrates that reasonable cause existed, the burden of proof shifts to the license holder to demonstrate by a preponderance of the evidence that the license holder was in full compliance with those laws or rules that the commissioner alleges the license holder violated, at the time that the commissioner alleges the violations of law or rules occurred.<sup>142</sup>

4. The Commissioner may suspend or revoke a license, or impose a fine, if a license holder fails to comply fully with applicable laws or rules, or if a license holder gives false or misleading information to the Commissioner during an investigation, or regarding compliance with applicable laws or rules.<sup>143</sup>

5. When applying these sanctions, the Commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.<sup>144</sup>

6. The Commissioner has demonstrated reasonable cause to take action against West Metro's license to provide chemical dependency treatment. West Metro has failed prove that it was in full compliance with the applicable laws or rules.

7. Revocation is the appropriate sanction, considering the nature, chronicity, and severity of the violations by West Metro, as well as the effect of those violations on the health, safety, or rights of persons served by the program.

Based upon the above Conclusions of Law, the Administrative Law Judge makes the following:

## **ORDER**

The Protective Order entered on August 30, 2007, shall remain in effect, and the record in this proceeding is not public.

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<sup>142</sup> Minn. Stat. § 245A.08, subd. 3(a) (2006).

<sup>143</sup> Minn. Stat. § 245A.07, subd. 3(a) (2006).

<sup>144</sup> Minn. Stat. § 245A.07, subd. 1 (2006).

## **RECOMMENDATION**

The Administrative Law Judge recommends that the Commissioner AFFIRM the revocation of West Metro's license to provide outpatient chemical dependency treatment.

Dated: July 23, 2008

s/Kathleen D. Sheehy  
KATHLEEN D. SHEEHY  
Administrative Law Judge

Reported: Digitally Recorded  
No transcript prepared

## **NOTICE**

This report is a recommendation, not a final decision. The Commissioner of Human Services will make the final decision after a review of the record. The Commissioner may adopt, reject or modify the Findings of Fact, Conclusions, and Recommendations. Under Minn. Stat. § 14.61, the final decision of the Commissioner shall not be made until this Report has been made available to the parties to the proceeding for at least ten days. An opportunity must be afforded to each party adversely affected by this Report to file exceptions and present argument to the Commissioner. Parties should contact Cal Ludeman, Commissioner, Minnesota Department of Human Services, P.O. Box 64998, St. Paul, MN 55164-0998, to learn the procedure for filing exceptions or presenting argument.

If the Commissioner fails to issue a final decision within 90 days of the close of the record, this report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a. The record closes upon the filing of exceptions to the report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative Law Judge of the date on which the record closes.

Under Minn. Stat. § 14.62, subd. 1, the agency is required to serve its final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

## **MEMORANDUM**

The Department has presented persuasive evidence that the revocation of West Metro's license is appropriate considering the nature, chronicity, and severity of its violations of law or rule and the effect of the violations on the health, safety, or rights of persons served by the program. Even before adoption

of the more rigorous rule standards in January 2005, West Metro demonstrated serious compliance issues, and its conduct since that time has failed to demonstrate that West Metro has either the ability or willingness to conform its treatment practices to the requirements of the law.

Between 2001 and 2007, the Department cited West Metro repeatedly and appropriately for violations concerning its deficient policies for identifying and investigating maltreatment issues; assessment of vulnerable adults; qualifications of its staff; compliance with background study requirements; and completion of assessments, treatment plans, and progress notes. West Metro's chronic failure to have staff members date and sign client records when written greatly diminishes the confidence that can be placed in the assessments, treatment plans, and especially the progress notes that do exist. The state of West Metro's client records lends support to the allegations made by former clients and employees that West Metro counselors were not taking notes in treatment sessions, not requiring people to be present for treatment, and not particularly caring whether clients were participating or not as long as they were signing into treatment.

Moreover, West Metro essentially refused to accept the limitations of its outpatient treatment license by operating its treatment facility in conjunction with a sober housing operation in a manner that suggested to clients that they were in residential treatment. [Client 6], who testified credibly at the hearing, said his experience at West Metro was "something other than treatment." As it turned out, he was correct. According to West Metro, [Client 6] was there simply as a "guest," and he wasn't really in treatment until a funding source was obtained, weeks after he thought he was admitted for treatment. But [Client 6] clearly thought he was in residential treatment; he signed in for treatment; he felt guilty about leaving treatment to perform maintenance work for West Metro and Lifetime Transitions; and it appears someone was billed for his treatment. Moreover, [Client 6] had a vested interest in completing treatment, because he had made commitments to other persons in his life that he would do so. And when West Metro told him he would have to repeat the treatment process, he ended up leaving West Metro, relapsing, going to a detoxification program, and from there to six months of residential treatment elsewhere. There is no question but that the experience [Client 6] had at West Metro was harmful to his recovery.<sup>145</sup>

This is not just a case, as West Metro argues, of an agency being overzealous about compliance with rigorous rules. The record here firmly compels the conclusion that the chronic, severe violations by West Metro resulted not from well-intentioned yet ineffectual efforts to comply with the rules, but rather resulted directly from its provision of high-volume treatment services

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<sup>145</sup> Based on the record, it appears unlikely that [Client 6's] experience was an isolated event. The Department found that half of the clients in the sample of files reviewed in November 2006 had signed in for treatment days or weeks before admission to the program.

with little regard for rules intended to assure the quality of those services. Moreover, when serious rule violations were discovered, West Metro took little responsibility for the magnitude of its noncompliance, consistently blaming former business partners, former clients, former employees, Rule 25 assessors, and even licensors for its problems. In addition to assuming little responsibility, West Metro's owner, counselor supervisor, and counselors (some of whom remain affiliated with West Metro to this day) have made multiple false statements to the Department about the storage, disclosure, authorship, and destruction of client records. The Department justifiably has little trust in West Metro's assurances that it would change its ways if it were permitted to continue operating.

Although the Administrative Law Judge has found that many of the false statements alleged in the revocation orders were knowingly made, there is insufficient evidence to conclude that two of the examples cited in the April 27, 2007, Revocation Order were made for the purpose of deceiving the Department. For example, [Client 2's] file contained a Rule 25 assessment providing that [Client 2] had never been arrested for driving while intoxicated; [Client 2] reported to the Department, however, that he had "possibly 17" DWI arrests. This inconsistency does raise questions about whether West Metro should have relied on the Rule 25 assessment as its own comprehensive assessment, but it does not equate to a knowingly false statement about the client's driving record by an employee of West Metro. The Rule 25 assessment was performed by a counselor at a different organization.<sup>146</sup>

In addition, one client's file contained inconsistent information about the client's discharge date. A progress note says the client completed the program on August 7, 2006; on the same page, there is a note stating the client was discharged on August 1, 2006. On another page, the counselor wrote that the client would be starting aftercare on August 7, 2006.<sup>147</sup> The record is inconsistent, and this is another example of poor recordkeeping, but there is insufficient evidence that it is a knowingly false statement. There is no evidence from the client as to when he was discharged, and no one asked the counselor (who testified at the hearing) about the conflict in these dates.

Two examples cited in the Second Amended Revocation Order, dated November 28, 2007, are similarly lacking in proof. One client's file contained a set of progress notes by counselor [SP11], for the period of time from March 19, 2007, to May 21, 2007. These notes were prepared on a computer, printed as one document, signed once by [SP11] at the end, and included in the client's file.<sup>148</sup> Another counselor, [SP9], copied these notes electronically and pasted them into another version of the progress notes, which indicate they cover the timeframe from March 19, 2007, through October 29, 2007. [SP9] printed the progress notes as one document, signed it at the end, and included this set as

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<sup>146</sup> DHS Exs. 16 & 36.

<sup>147</sup> DHS Ex. 27 at DHS 277, 279.

<sup>148</sup> DHS Ex. 30 at DHS 493-94.

well in the client's file.<sup>149</sup> The progress notes were clearly stored electronically, and they were not dated and signed when written, in violation of DHS rules, but if the counselor had intended to deceive anyone about authorship, it is hard to see why she would have left both versions in the file. Another client's file contains a progress note dated June 13, 2007, stating that the client was attending A.A. meetings; his sign-in sheets, however, indicate that he was not.<sup>150</sup> It cannot be determined on this record which document is correct, or whether the counselor's note is intentionally false.

Although these specific allegations were not proved, the bulk of the citations were fully supported by the record. The Administrative Law Judge has read the statements of support by former clients of West Metro, many of whom appear to have been in treatment prior to 2006.<sup>151</sup> But these sincere expressions of support must be balanced against the nature, chronicity, and severity of the violations by West Metro with regard to almost every aspect of licensing requirements. The Administrative Law Judge accordingly recommends that the revocation orders be affirmed.

**K.D.S.**

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<sup>149</sup> DHS Ex. 30 at DHS 486-92.

<sup>150</sup> DHS Exs. 33 & 34.

<sup>151</sup> A number of these statements were submitted by people who came to West Metro from Ohio. One such client, [Client 1], told DHS staff in an interview that he started treatment at West Metro after West Metro sent him a bus ticket to come from Ohio. He said he started treatment on October 11, 2006. When questioned by DHS, [Client 1] said neither he nor his mother had ever lived in the Twin Cities. [Client 1's] file contains a Rule 25 assessment performed by a counselor at Turning Point, who placed [Client 1] at West Metro on October 17, 2006. The assessment provides that [Client 1] was a resident of Richfield, Minnesota, and his mother resided in St. Paul. West Metro's "Intake Assessment" does not address the client's residence, nor does any other document in the file reference his residence in Ohio. See Ex. 68.